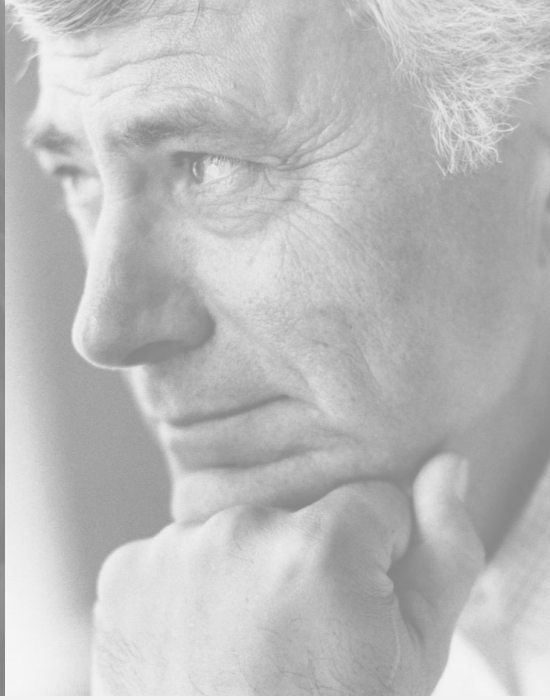
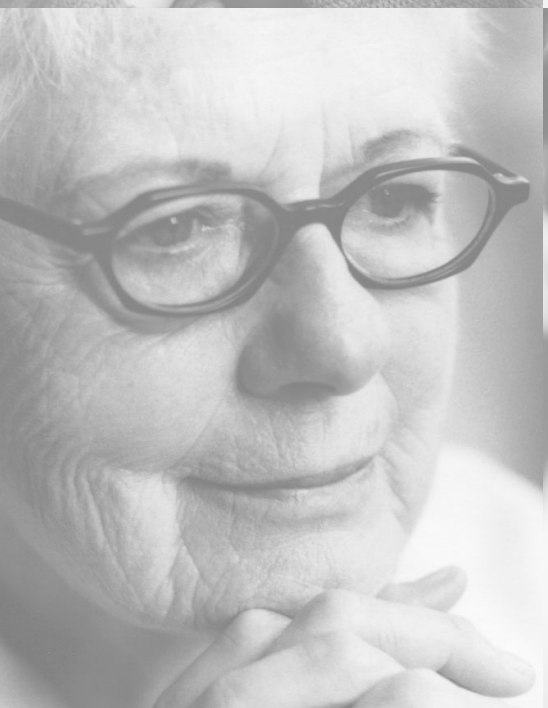


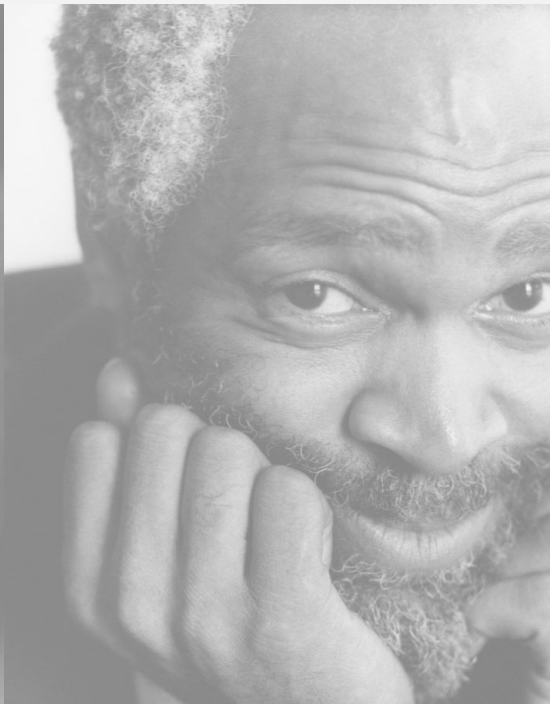



THE MARYLAND COMPREHENSIVE CANCER CONTROL PLAN

OUR CALL TO ACTION

2004–2008





THIS CANCER PLAN IS DEDICATED TO ALL THE COURAGEOUS MARYLANDERS AND THEIR FAMILIES WHO FIGHT OR HAVE FOUGHT A BATTLE AGAINST CANCER. THE 2004–2008 MARYLAND COMPREHENSIVE CANCER CONTROL PLAN SERVES AS A MONUMENT TO YOUR VALIANT EFFORTS.

"TO BE EFFICIENT AND EFFECTIVE,

WE MUST WORK WITH OUR

PARTNERS TO CHANGE THE CATEGORICAL

CANCER MINDSET INTO ONE

COMPREHENSIVE STRATEGY."

James S. Marks, MD, MPH
Director, National Center for Chronic Disease
Prevention and Health Promotion

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ACKNOWLEDGMENTS

Over the course of a two-and-a-half year planning process, citizens from around the state of Maryland donated their time, expertise, and experience to the development of the 2004–2008 Maryland Comprehensive Cancer Control Plan (MCCCP). Many individuals and organizations contributed to the development of this plan.

Thanks must first go to the individuals who made up the Core Planning Team and the committees that were charged with developing the various chapters of this cancer plan. The combined efforts of the researchers, lay citizens, public health staff, and health care providers that served on the Core Planning Team and on committees resulted in chapters that truly capture current issues in cancer control and offer strategies that will make an impact on the cancer burden in this state. A list of committee members is provided at the beginning of each chapter.

Researchers and faculty at the University of Maryland, Baltimore's Greenebaum Cancer Center and School of Medicine and at Johns Hopkins University's Bloomberg School of Public Health and The Sidney Kimmel Comprehensive Cancer Center provided invaluable assistance. In addition, researchers from the Specialized Programs of Research Excellence (SPORE) programs at Johns Hopkins University interpreted and presented data to the various committees involved with this plan. The American Cancer Society contributed to the planning effort by providing representation on the Core Planning Team and every working committee.

The members of the Maryland State Council on Cancer Control who joined, and in some cases, provided leadership for, various committees. Council members contributed their time, organizational resources, and expertise during the entire planning process.

Various offices within the Department of Health & Mental Hygiene, including the Center for Cancer Surveillance and Control, Center for Health Promotion, Education, and Tobacco Use Prevention, Office of Oral Health, and Center for Preventive Health Services contributed staff resources in the creation of the cancer plan. Special thanks must go to Katherine Shockley, the program coordinator of the 2004–2008 Maryland Comprehensive Cancer Control Plan. Without her leadership and perseverance, there would be no cancer plan.

Finally, we thank the citizens of Maryland for embracing the concept of comprehensive cancer control and sharing their views by attending town hall meetings, providing feedback via the cancer plan website, and participating on committees.

EXECUTIVE SUMMARY

The Maryland Comprehensive Cancer Control Plan 2004–2008: Our Call to Action is a resource and guide for health professionals who are involved in planning, directing, implementing, evaluating, or performing research in cancer control in Maryland. This plan represents the coordinated effort of over 200 individuals across the state that came together through 14 committees and a Core Planning Team to develop a document that reflects the needs of Marylanders. This plan was not developed by, or for, any one organization. It was developed by a broad partnership of public and private stakeholders whose common mission is to reduce the burden of cancer in Maryland. This plan was developed by Marylanders for Marylanders.

The State of Maryland Department of Health & Mental Hygiene, on behalf of many partnering organizations, received a cooperative agreement from the Centers for Disease Control and Prevention in 2001 to develop a comprehensive cancer control plan for the state. Although there have been two previous Maryland Cancer Control Plans, this plan is more comprehensive in nature and has involved the participation of broader and more diverse organizations in its development than did the previous two plans.

Comprehensive cancer control is defined by the Centers for Disease Control and Prevention as "an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation." Comprehensive cancer control is an emerging model that integrates a range of cancer control activities to maximize the use of limited resources to achieve desired cancer prevention and control outcomes. The structure of this plan follows the CDC's definition of comprehensive cancer control. This plan includes chapters that cover cancer control from primary prevention through survivorship and palliative care. Although there are over 100 different cancer sites, it was not feasible to cover every cancer site in this plan. Rather, this plan covers those cancer sites, interventions, or issues that we know from research will have an impact on cancer incidence, morbidity, mortality, and quality of life.

The plan starts with a chapter describing an overview of the burden of cancer in Maryland and a cancer control model for the state. The Plan is then divided into sections. The first section deals with primary prevention of cancer. Chapters in this section focus on tobacco-use prevention and cessation and lung cancer, diet and physical activity, ultraviolet radiation and skin cancer, and environmental issues. The second section addresses secondary prevention or the early detection and treatment of cancer. Chapters included in this section are cancer site-specific. There are individual chapters on breast, cervical, colorectal, prostate, and oral cancer. The next section deals with tertiary prevention. Chapters included in this section cover pain management and end-of-life care. The remaining chapters of the plan highlight crosscutting issues that are of importance to cancer control including cancer disparities, cancer surveillance, and patient issues and cancer survivorship. The Preface describes the background, the past Maryland Cancer Plans, and the processes used to develop the Comprehensive Cancer Control Plan. The Appendix contains information on data sources and methods.

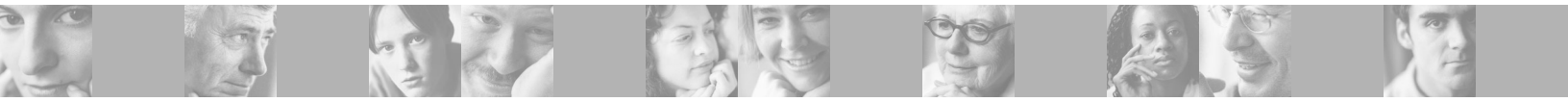
Each chapter was written and/or edited by 10 to 20 Maryland experts in that area. A committee was formed for each chapter, and in general consisted of epidemiologists, health care providers, researchers, cancer survivors, and other representatives from local and state health departments, governmental agencies, community-based organizations, academic health centers, hospitals and other health care facilities, and cancer support groups. Committee members, as well as guest speakers and chapter contributors, are listed at the beginning of each chapter.

Each committee reviewed epidemiologic data, scientific research, and existing programs and resources, espe-

cially those available in Maryland. They identified gaps and barriers to cancer control in Maryland for the issues addressed in their respective chapter, and from these developed goals, objectives, and strategies. In general, the outline of each chapter is as follows: a review of data in Maryland relevant to the chapter's topic, a discussion of disparities, existing programs and resources, gaps and barriers, and then a section listing goals, objectives, and strategies. In addition, each chapter has a measurable target for change.

The goals, objectives, and strategies that are provided at the end of each chapter serve as a guide to all organizations in the state and show areas where additional attention is needed. The objectives are far-reaching and complex. No one organization can carry out all of these activities. Rather, these goals, objectives, and strategies are listed as our call to action to encourage any organization involved in any aspect of cancer control to address one or more of these goals and objectives, and apply the appropriate strategies as resources and opportunities arise.

Following is a list of the goals and objectives for each chapter in the plan. The objectives relate to public education, professional education, service delivery (such as screening, diagnosis and treatment), health insurance issues, research, access and utilization, data collection, analysis, and dissemination and policy issues. Specific recommended strategies for each objective are found in the goals, objectives, and strategies sections of each chapter.



Executive Summary
Goals and Objectives

Chapter 2:
Cancer Surveillance

Goal:
Fully implement cancer surveillance—the development, collection, analysis, and dissemination of cancer information—in Maryland.

Objective 1:
Develop, maintain, and enhance data systems to ensure accurate, timely, and complete information needed for the prevention and control of cancer.

Objective 2:
Expand access to, and analysis of, the databases used for cancer surveillance in Maryland in order to better meet the information needs of program planners, policy makers, researchers, and the public.

Objective 3:
Broadly disseminate cancer surveillance findings to promote cancer awareness, policy development, and implementation of cancer control programs.

Chapter 3:
Cancer Disparities

Goal:
Reduce cancer health disparities in Maryland.

Objective 1:
Increase public and community awareness about cancer health disparities and cancer prevention, screening, and treatment in Maryland.

Objective 2:
Develop and implement health care programs designed to reduce cancer disparities among targeted populations in Maryland.

Objective 3:
Increase cancer disparities documentation and intervention on a systematic basis in Maryland.

Objective 4:
Increase provider education and reimbursement aimed at reducing cancer disparities.

Objective 5:
Improve access to, and utilization of, cancer screening and treatment options for underserved populations.

Objective 6:
Improve the quality of cancer care received by racial/ethnic minorities.

Chapter 4: Patient Issues and Cancer Survivorship

Goal:
Enhance the quality of life for all cancer survivors in Maryland.

Objective 1:
Enhance access to information and resources for Maryland cancer survivors, their friends, and families.

Objective 2:
Reduce the financial burden on cancer survivors and their families.

Objective 3:
Ensure that all cancer survivors have access to psychosocial support services throughout all phases of their cancer experience.

Objective 4:
Address the needs of long-term cancer survivors in Maryland.

Chapter 5: Tobacco-Use Prevention and Cessation and Lung Cancer

Goals:
Substantially reduce tobacco use by Maryland adults and youth.

Substantially reduce youth and adult exposure to secondhand smoke.

Objective 1:
Fund Maryland's comprehensive Tobacco-Use Prevention and Cessation Program at least at the minimum level recommended by the Centers for Disease Control and Prevention.

Objective 2:
Establish public policy that supports state and local bans on smoking in all public places and workplaces.

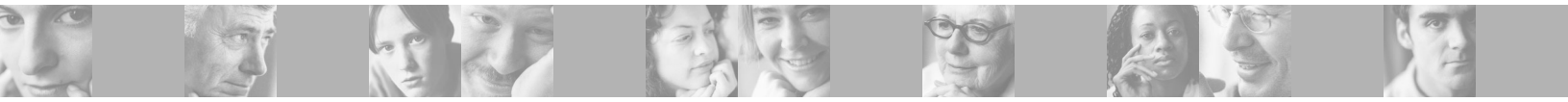
Objective 3:
Increase the excise tax on cigarettes to $1.50.

Objective 4:
Enact civil prohibition on the sale of tobacco to youth under 18 years of age.

Objective 5:
Ensure access to tobacco-use cessation services.

Objective 6:
Enhance existing program activities.

Objective 7:
Continual evaluate and improve state and local programs.



Chapter 6: Diet and Physical Activity

Goal:
Reduce the burden of cancer in Maryland through the promotion of healthy diet, healthy weight, and physical activity as a means of cancer prevention.

Objective 1:
Increase awareness of and demonstrate healthy eating and physical activity patterns among Maryland families and communities.

Objective 2:
Increase the prevalence of healthy diet, healthy weight, and physical activity among Maryland youth.

Objective 3:
Increase access to a healthy diet and physical activity at Maryland workplaces.

Objective 4:
Increase the number of health care providers offering preventive nutrition and physical activity services.

Objective 5:
Engage the public with appropriate health messages related to nutrition, obesity, physical activity, and cancer via the media.

Objective 6:
Increase scientific knowledge regarding the relationship among nutrition, physical activity, and cancer.

Chapter 7: Ultraviolet Radiation and Skin Cancer

Goals:
Prevent increases in mortality from melanoma cancer.

Increase utilization of sun-safe behaviors.

Objective 1:
Increase public awareness about sun safety and skin cancer.

Objective 2:
Increase physician awareness about sun safety and skin cancer.

Objective 3:
Increase the number of melanoma cancers diagnosed at an early stage.

Objective 4:
Develop improved data to document the prevalence of skin cancer examinations and appropriate diagnosis and follow-up of melanoma and other skin cancers in Maryland.

Objective 5:
Implement policy changes to increase the use of sun-safe behaviors, particularly among youth in Maryland.

Chapter 8: Environmental Issues and Cancer

Goal:
Improve prevention of environmentally related cancers.

Objective 1:
Improve cancer prevention program evaluation.

Objective 2:
Improve data collection and carcinogen exposure assessment.

Objective 3:
Improve information regarding occupational risk factors for cancer.

Objective 4:
Enhance collaboration between academic research institutions and state and local public health departments.

Objective 5:
Improve recognition and screening for cancers associated with infectious agents.

Objective 6:
Reduce the differences in cancer rates attributable to socioeconomic status or racial status.

Chapter 9: Colorectal Cancer

Goals:
Reduce colorectal cancer mortality.

Reduce disparities in the incidence and mortality of colorectal cancer.

Objective 1:
Increase the rate of screening for colorectal cancer of those aged 50 and older by increasing the public's knowledge of colorectal cancer risk factors, symptoms, screening recommendations, and options.

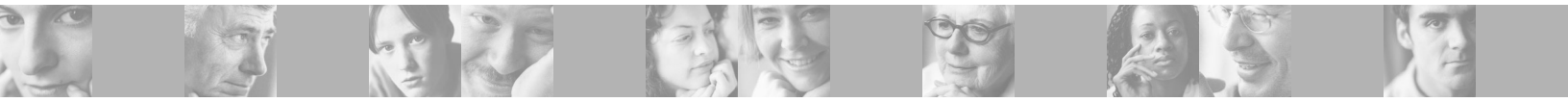
Objective 2:
Clarify myths and dispel fears about colorectal cancer related to appropriate screening and prevention methods.

Objective 3:
Increase the knowledge of primary care providers (including family physicians, internists, and gynecologists) of appropriate colorectal cancer screening recommendations, and increase the proportion of providers who recommend or provide screening for colorectal cancer.

Objective 4:
Increase the trust of the public in the health care system.

Objective 5:
Promote health insurance coverage for colorectal cancer screening methods that are appropriate for each individual.

Objective 6:
Overcome barriers to screening, including difficult preprocedure colonic preparation, transportation issues, scheduling and timing issues including conflict with work schedules, living alone, etc.



Objective 7:
Ensure that patients with insurance coverage for colorectal cancer screening are screened.

Objective 8:
Increase available funding to pay for diagnosis and treatment for all who are screened and found to need additional care.

Objective 9:
Overcome language, literacy, and cultural barriers in health care providers' offices.

Objective 10:
Increase funding for colorectal cancer screening among uninsured, low-income Maryland residents, especially in Baltimore City.

Objective 11:
Ensure that there are sufficient providers to perform colonoscopy and/or sigmoidoscopy for all who require the procedures in Maryland.

Objective 12:
Ensure that there are sufficient providers who can perform initial physicals and clearance examinations for the uninsured, accept low-income clients and clients with Medicare and Medical Assistance, and have flexible hours necessary to working patients.

Objective 13:
Communicate the importance of primary prevention of colorectal cancer through healthy lifestyles.

Chapter 10: Breast Cancer

Goals:
Reduce the incidence of breast cancer in Maryland.

By 2008, reduce the proportion of late stage breast cancers diagnosed in all women and reduce the rates of late diagnosis in African-American women to that of white women.

Ensure that all women who develop breast cancer are diagnosed with Stage 1 disease with <1 cm tumors.

Research factors contributing to high incidence and mortality rates in Maryland and develop appropriate interventions.

Ensure access to prevention, screening, treatment, and follow-up care for all Maryland residents.

Preserve the Cigarette Restitution Fund (CRF) for addressing health issues in Maryland.

Objective 1:
Determine why Maryland has high breast cancer incidence and mortality rates compared to other states in the nation.

Objective 2:
Continue to monitor breast cancer prevention research and promote activities to prevent breast cancer.

Objective 3:
Increase breast cancer risk assessment and risk-appropriate strategies.

Objective 4:
Ensure continued access to early detection and treatment of breast cancer.

Objective 5:
Increase the number of providers that perform minimally invasive biopsy techniques.

Chapter 10: Breast Cancer *continued*

Objective 6:

Promote optimum state-of-the art breast cancer care for all breast cancer patients regardless of regional, racial, age, or other disparities.

Objective 7:
Increase the number of individuals with ductal carcinoma in situ and early stage breast cancer that receive treatment appropriate for their diagnosis.

Objective 8:
Provide breast cancer survivors with information regarding the long-term effects of treatment.

Chapter 11: Prostate Cancer

Goals:
Reduce prostate cancer mortality.

Reduce disparities in the mortality of prostate cancer.

Monitor the proportion of men who have had a PSA test and a digital rectal examination.

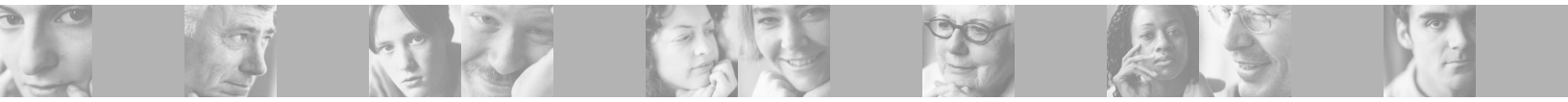
Objective 1:
Increase public education about prostate cancer.

Objective 2:
Continue to monitor research findings regarding the effectiveness of primary and secondary prevention interventions in reducing prostate cancer mortality.

Objective 3:
Promote informed decisionmaking prior to screening with PSA and digital rectal examination.

Objective 4:
Promote education about prostate cancer treatment and support services for patients diagnosed with prostate cancer.

Objective 5:
Monitor research in primary, secondary, and tertiary prevention.



Chapter 12: Oral Cancer

Goals:
Reduce oral cancer mortality.

Reduce disparities in the incidence and mortality of oral cancer.

Objective 1:
Increase oral cancer literacy among Marylanders.

Objective 2:
Increase provider education and training related to oral cancer prevention and early detection.

Objective 3:
Increase public access to oral cancer prevention, early detection, and treatment services.

Objective 4:
Increase scientific knowledge regarding oral cancer.

Objective 5:
Maintain a centralized, statewide mechanism for support of oral cancer initiatives.

Chapter 13: Cervical Cancer

Goal:
Reduce cervical cancer mortality in Maryland.

Objective 1:
Increase awareness in the general public of cervical cancer screening recommendations and availability of programs.

Objective 2:
Increase cervical cancer screening in women who have not been screened in the last five years, especially older women, and increase compliance with recommended follow-up.

Objective 3:
Ensure that all providers have access to state-of-the-art guidelines for the management of cervical abnormalities.

Objective 4:
Ensure access to medical care for all.

Objective 5:
Conduct Maryland-specific surveillance research on barriers to cervical cancer detection and treatment by establishing a statewide follow-back study mechanism to allow for monitoring of failures through follow-back and to evaluate and modify intervention strategies.

Objective 6:
Determine why there are discrepancies in survival among different segments of the state population, taking into account multiple factors including race and age.

Chapter 14: Pain Management

Goal:
Increase awareness of, and access to, comprehensive pain assessment and management services for all cancer patients in Maryland in light of the current public health crisis of inadequate pain control.

Objective 1:
Increase provider awareness and training regarding appropriate pain assessment, management, and relevant regulatory issues.

Objective 2:
Increase provider reimbursement for cancer pain therapies.

Objective 3:
Increase consistency among different health care systems regarding compliance and adherence to standards for cancer pain assessment and management.

Objective 4:
Eliminate barriers due to cultural, age, sex, and income disparities and ensure equal access to pain management therapies within the health care system.

Objective 5:
Increase scientific knowledge regarding assessment and treatment of cancer pain.

Objective 6:
Increase public knowledge and awareness of cancer pain management practices and referral sources.

Objective 7:
Enhance existing legislation and create new regulations designed to increase awareness of, and access to, comprehensive cancer pain assessment and management services for all cancer patients in Maryland.

Chapter 15: End-of-Life Care

Goal:
Increase the number of Maryland cancer patients, as well as their family members and friends, receiving quality end-of-life care and related services.

Objective 1:
Expand provider education and training related to end-of-life care.

Objective 2:
Increase public awareness of end-of-life issues.

Objective 3:
Improve access to end-of-life care for all Marylanders with specific attention to improving physician reimbursement for appropriate end-of-life care.

Objective 4:
Enhance access to the continuum of end-of-life care services throughout the state.

Objective 5:
Enhance scientific research into all aspects of end-of-life care.

PREFACE

Background

In 1994, the Centers for Disease Control and Prevention (CDC) worked with state cancer control staff throughout the nation and other cancer organizations to define the concept of comprehensive cancer control. CDC has defined comprehensive cancer control as "an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation." Comprehensive cancer control is an emerging model that integrates a range of cancer control activities to maximize the use of limited resources to achieve desired cancer prevention and control outcomes. In 2003, the CDC provided funding for 12 states to develop comprehensive cancer control plans. Sixteen states have current comprehensive cancer control plans. The principles governing comprehensive cancer control are shown in Table 1.

Past Maryland Cancer Plans

In 1988, the Maryland Department of Health & Mental Hygiene (DHMH) received a cooperative agreement from the National Cancer Institute entitled "Data-Based Interventions in Cancer Control." This cooperative agreement provided funds to DHMH to gather and analyze data on the burden of cancer in Maryland, develop a statewide cancer control plan, and implement one strategy identified in the plan.

As a result of this cooperative agreement, the first Maryland Cancer Control Plan was published in 1991. This plan represented a collaborative effort among several different offices within DHMH as well as community and academic organizations in the state. The priorities of this plan were the prevention and cessation of tobacco use and the early detection and treatment of breast and cervical cancer. Because of the priorities enumerated in the 1991 Maryland Cancer Control Plan, a statewide breast cancer screening program was initiated in cooperation with 26 community hospitals,

Table 1.
Comprehensive Cancer Control Principles

- Scientific data and research are used systematically to identify priorities and inform decision-making.
- The full scope of cancer care is addressed, ranging from primary prevention to early detection and treatment to end-of-life issues.
- Many stakeholders are engaged in cancer prevention and control, including the medical and public health communities, voluntary agencies, insurers, businesses, survivors, government, academia, and advocates.
- All cancer-related programs and activities are coordinated, thereby creating integrated activities and fostering leadership.
- The activities of many disciplines are integrated. Appropriate disciplines include administration, basic and applied research, evaluation, health education, program development, public policy, surveillance, clinical services, and health communications.

Source: CDC, Division of Cancer Prevention and Control. Fact Sheet on Comprehensive Cancer Control, 2003.

and a state-funded breast and cervical cancer diagnosis and treatment program was initiated for uninsured and underinsured, low income, non-Medical Assistance eligible Maryland residents. Subsequently, DHMH was awarded a multi-year cooperative agreement from the CDC to develop a statewide breast and cervical cancer screening program.

In 1996, the Maryland Cancer Control Plan was updated. The priorities identified in the second edition of the Maryland Cancer Control Plan included the prevention and cessation of tobacco use and the early detection of colorectal, breast, and cervical cancer.

Cancer Control History in Maryland

In Maryland, there exists an atmosphere of support and commitment to reduce cancer incidence and mortality rates and the suffering caused by cancer. The governor's office established the State Council on Cancer Control by an executive order on June 26, 1991 and updated this executive order in November 1997 and December 2002. Since the formation of the Maryland State Council on Cancer Control, Maryland has experienced an unprecedented period of partnership among the Maryland legislature, local health departments, and the major academic cancer centers.

The Maryland General Assembly has passed several laws related to cancer control that benefit residents. For example, in 1991, the Maryland General Assembly passed a law requiring Maryland health insurers to provide a benefit covering the cost of mammography screening. Since then the Maryland General Assembly has passed legislation on mandated benefits for colorectal cancer screening, prostate cancer screening, and laws to cover the cost of clinical trials.

With funds derived from the November 1998 Master Tobacco Settlement Agreement with the tobacco industry, the Maryland General Assembly created the Cigarette Restitution Fund (CRF) as the repository of all settlement funds received by Maryland. In the spring of 2000, the Maryland General Assembly crafted and then enacted SB 896 and HB 1425 creating the Cigarette Restitution Fund Program (CRFP) to implement strategies to conquer cancer and end smoking in Maryland.

As a direct result of the CRFP, Maryland has a strong, statewide network of cancer and tobacco community health coalitions that are comprised of individuals and organizations that are committed to addressing the cancer and tobacco-use prevention needs of local communities.

In addition, there are numerous and varied cancer prevention, education, and screening programs, cancer research programs, and tobacco-use prevention and cessation programs.

Development Process

The planning stage of the comprehensive cancer plan was initiated with a leadership institute sponsored by the CDC and the American Cancer Society (ACS). Representatives from the Maryland State Council on Cancer Control, University of Maryland School of Medicine, and ACS attended the leadership institute and met several times to discuss initial planning strategies. A Core Planning Team (CPT) was formed in April 2001 and included representatives from the Maryland DHMH, ACS, University of Maryland, Johns Hopkins University, and local health departments. The CPT developed a grant application for funding from CDC to develop a comprehensive cancer plan. In October 2001, DHMH was awarded a cooperative agreement from CDC, on behalf of the CPT, to develop a comprehensive cancer plan.

The membership of the CPT was then expanded to include representation from other nonprofit, health care, and community organizations from around the state. The overarching goal was to have broad representation within a small practical group that could reach consensus and make efficient decisions. The purpose of the CPT was to provide oversight and guidance to the development of an updated Maryland Comprehensive Cancer Control Plan.

Among its many activities, the CPT developed the overall framework in which the plan would be developed, drafted the outline of chapters to be included in the plan, determined the committees that would be formed, and assisted with recruiting membership for each committee. The CPT has continued to meet on an ongoing basis to provide direction to the development of the plan.

Committee Structure

The cancer control planning process in Maryland involved the establishment of working committees to focus on individual cancer topics and generate recommendations for cancer control within those respective topics. Several considerations were made during the recruitment process for committee members. First, the aim was to fill the committees with approximately 10–20 members each. It was agreed that committees larger than 20 members may have difficulty meeting

deadlines and obtaining consensus and that committees with fewer than 10 members would provide inadequate input. Second, it was vital that committee members be diverse, balanced, and include the necessary scientific expertise relevant to the committee's topic. Special efforts to were made to recruit minorities as well as appropriate professionals, including epidemiologists and health care providers.

Committee members were recruited from DHMH, local health departments, other government agencies, community-based organizations, hospitals and other health care facilities, advocacy organizations, cancer support groups and survivor networks, and the two largest academic centers in Maryland (Johns Hopkins University and the University of Maryland). Individual recruitment was then conducted as needed to maintain balance and diversity in membership. A total of over 200 individuals were recruited to serve on the 14 committees. Members of each committee, as well as guest speakers and chapter contributors, are listed at the beginning of each chapter in this plan.

A chairperson was selected for each of the 14 committees. DHMH staff worked closely with each chairperson to develop agendas, timelines, and materials for committee meetings and to coordinate operational matters for each committee. Over the course of several meetings, the committees reviewed materials and employed a variety of methods to accomplish their goal, which was to develop a set of recommendations that would form the basis of the corresponding chapter in the new cancer plan. Most committees dedicated one or more meetings to the review of epidemiologic data and scientific literature and to the compilation and assessment of information on current programs and policies. The committees utilized topical brainstorming and the nominal group process to generate and prioritize ideas, ultimately drafting a list of strategies for inclusion in their corresponding chapter.

Town Hall Meetings

In an effort to gain public input for the 2004–2008 Maryland Comprehensive Cancer Control Plan, a series of seven public town hall meetings were held across the state between July 16 and August 8, 2002. The details of the meetings are shown in Table 2.

A staff person facilitated each meeting and panelists consisted of members of the Maryland State Council on Cancer Control, the CPT, and the working committees. On the Eastern Shore, two sites incorporated the use of video-conferencing technology.

Over 170 people participated in the town hall meetings and provided input on the cancer issues faced by Marylanders. Testimony was compiled for each meeting and organized by subject area to correspond with the 14 committee topics. Relevant testimony was then returned to each committee for review and incorporation into their recommendations. A complete summary of proceedings of the town hall meetings is available on the cancer plan website at http://www.marylandcancerplan.org/meetings.html.

Consensus Conference

A statewide consensus conference was held on October 16, 2002 and, with over 300 people in attendance, served as the first public forum for the 14 committees to present their preliminary findings and recommendations. The two main goals of the conference were (1) to share the accomplishments of the 14 working committees and (2) to provide an arena for public comment on the recommendations of the committees and to serve as another venue for public involvement in the development of the new cancer plan.

Participants were asked to complete a feedback packet, which allowed for comment on specific content areas of each presentation. Feedback was then compiled and given to each committee chairperson and/or chapter writer for consideration. Each of the PowerPoint presentations, as well as complete transcripts of the feedback submitted by participants, is available on the cancer plan website at http://www.marylandcancerplan.org/presentations.html.

Writing Phase

Writing of the cancer plan commenced in early 2003 after the committees reviewed the feedback from the consensus conference. After all committee meetings were complete, a chapter writer was recruited from the membership of the committee. In some instances multiple writers were recruited for a chapter. Detailed chapter outlines for each chapter were developed by DHMH staff and provided to all chapter writers as a means to facilitate the writing process. A committee review process was conducted for all chapters in this cancer plan. Committee members were provided with a draft chapter and were asked to submit comments and suggestions regarding the content and structure of the document. Editorial, design, and layout services were performed by Evins Design of Baltimore, MD.

Table 2
Maryland Regions Served by the 2002 Town Hall Meetings

Date	Location	Region Served
July 16 6:00–8:00 p.m.	Prince George's Hospital Center, Cheverly, MD	Prince George's County
July 18 6:00–8:00 p.m.	Anne Arundel County Public Library Linthicum, MD	Central Maryland
July 25 6:00–8:00 p.m.	Charles County Health Department White Plains, MD	Southern Maryland
July 30 6:00–8:00 p.m.	American Cancer Society Silver Spring, MD	Montgomery County
August 1 6:00–8:00 p.m.	Bon Secours Baltimore Health System Baltimore, MD	Baltimore City
August 6 4:00–6:00 p.m.	Robinwood Medical Center Hagerstown, MD	Western Maryland
August 8 4:00–6:00 p.m.	Eastern Shore Oncology Regional Cancer Center Easton, MD University of Maryland, Statewide Health Network Salisbury, MD	Eastern Shore

Evaluation of the Planning Process

An evaluation committee consisting of members of the CPT was formed to monitor the evaluation component of the cancer control plan development process. The evaluation committee chose the Content-Input-Process-Product model (CIPP) as the basis for evaluating the planning process and adapted the model for use in Maryland. Use of the CIPP model facilitates analysis of information and data so that modifications can be considered, alternatives examined, and final decisions made. Evaluation was accomplished through a continuous and systematic approach of feedback acquisition at each committee meeting for the purpose of modifying the planning process as needed.

Website

The cancer plan website (http://www.marylandcancer plan .org) was an invaluable communication tool throughout the planning process. The website allowed for quick and easy information dissemination to those participating in the planning process, including announcements about upcoming meetings, event information and registration, and planning updates. In addition, the website provided the comprehensive cancer planning process in Maryland with an elevated public profile and provided access to a broad audience. Through the availability of a variety of electronic forms, the website allowed input and participation from many individuals not directly involved in cancer control in Maryland. The website will serve as the online home for the cancer plan as well as the future home for information related to the implementation process.